New Jersey Department of Health
Public Health and Food Protection Program
P.O. Box 369
Trenton, New Jersey 08625-0369
https://nj.gov/health/ceohs/phfpp/wfc
609-826-4935 | wfc@doh.nj.gov

LICENSE NO. _____ **INVOICE NO.** _____

CURRENT EXPIRATION DATE: _____

RENEWAL APPLICATION FOR LICENSE TO OPERATE A WHOLESALE FOOD-COSMETIC ESTABLISHMENT

PURSUANT TO N.J.S.A. 24:15-1

Failure to apply for renewal may subject you to penalty as provided by law. Expiration date appears on license. Provide all information requested. If you have discontinued operations, complete last section only. Submit your completed application as an email attachment to: wfc@doh.nj.gov

LICENSED LOCATION ADDRESS: _____

Licensee Name:

Trade Name:

Mailing Address:

City: State: Zip Code:

Phone Number _____

Email Address _____

☐ **I would like to receive email renewal notices**

Federal Tax ID _____

IF INFORMATION ON FILE HAS CHANGED, MAKE NECESSARY CORRECTIONS BELOW

- ☐ Change in Trade Name
- ☐ Change in Corporate Structure
- ☐ Change in Mailing Address
- ☐ Change in Licensed Location *
- ☐ Change in Ownership/Tax ID *

* If the owner/tax ID has changed or the operations have moved to a different location, the existing license number will be deactivated. An initial application form F-29 is required for a new license. Find the initial application on our website: nj.gov/health/ceohs/phfpp/wfc

INDICATE ANNUAL GROSS WHOLESALE BUSINESS based on your last fiscal year.

		RENEWAL FEE
☐	1. Less than $100,000.00	$150.00
☐	2. Excess of $100,000.00, but not in excess of $500,000.00	$500.00
☐	3. Excess of $500,000.00	$1000.00

VISIT **NJ.GOV/HEALTH/CEOHS/PHFPP/WFC** TO PAY ONLINE WITH A CHECK OR CREDIT CARD

Indicate the payment transaction information below. Online payment alone is not sufficient to renew your license. Complete this form (an electronic version of the renewal form is available at the website above) and submit as an attachment via email to **wfc@doh.nj.gov** OR make check payable to *NJ Department of Health* and mail to the address at the top of this form. If you submit via email, keep the original paper form for your records. Do not submit in duplicate.

PAYMENT CONFIRMATION # _____ DATE OF PAYMENT _____ AMOUNT _____

CERTIFICATION BY APPLICANT

I hereby certify that the information given in this application is true and complete to the best of my knowledge, information, and belief.

Name and Title of Applicant	Direct Contact Phone Number
Signature of Applicant	Direct Email Address

TO REQUEST DEACTIVATION OF YOUR LICENSE, COMPLETE BELOW. Write "NA" if a field is not applicable.

Date Operation Discontinued	Reason for Discontinuance
Date Sold	Name and Address of Purchaser
Signature of Former Operator	Address of Former Operator

SUBMIT COMPLETED APPLICATION AS AN ATTACHMENT BY EMAIL TO: WFC@DOH.NJ.GOV